wisconsin Medicaid update and BadgerCare

July 2003 ● No. 2003-46
PHC 1978

Wisconsin Medicaid and BadgerCare Information for Providers

To:
Case Management Providers
HMOs and Other Managed Care Programs

Changes to local codes and paper claims for case management services as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important changes to local codes and paper claims for case management services effective October 2003, as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). These changes include:

- Adopting nationally recognized codes to replace currently used Wisconsin Medicaid local codes.
- Revising CMS 1500 paper claim instructions.

A future *Update* will notify providers of the specific effective dates for the various changes.

Changes as a result of HIPAA

This *Wisconsin Medicaid and BadgerCare Update* introduces important billing changes for case management services. These changes will be implemented in October 2003 as a result of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). A future *Update* will notify providers of the specific effective dates for the various changes. These changes are not policy or coverage related (e.g., documentation requirements), but include:

- Adopting nationally recognized procedure codes, place of service (POS) codes, and modifiers to replace currently used Wisconsin Medicaid local codes.
- Revising CMS 1500 paper claim instructions.

Note: Use of the national codes that will replace Wisconsin Medicaid local codes and revised paper claim instructions prior to implementation dates may result in claim denials. Specific implementation dates will be published in a future *Update.*

Adoption of national codes

Wisconsin Medicaid will adopt nationally recognized medical codes to replace currently used Wisconsin Medicaid local codes for case management services.

Allowable procedure codes

Wisconsin Medicaid will adopt the nationally recognized code T1017 to replace currently used Wisconsin Medicaid local procedure codes for case management services. Providers will be required to use this Healthcare Common Procedure Coding System (HCPCS) procedure code. Refer to Attachment 1 of this *Update* for a procedure code conversion chart.

Modifiers

Providers will be required to use two HCPCS modifiers when submitting claims for case management services: one to distinguish which service is being provided and an additional modifier to identify if the recipient is part of the Community Options Program (COP) or not (non-COP). Refer to Attachment 1 for a list of national modifiers locally defined for case management services.

Place of service codes

Nationally recognized two-digit POS codes will replace the one-digit Wisconsin Medicaid POS codes. Refer to Attachment 2 for a list of allowable POS codes for case management services.

Diagnosis codes

Providers will be required to use I*nternational Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis codes in place of locally assigned target population codes (Element 21) on the CMS 1500 claim form. Refer to Attachment 3 for the list of target population codes and their corresponding ICD-9-CM diagnosis codes.

Time units

The HCPCS procedure code, T1017, which will replace the local codes for case management services includes an indication of "15 minutes" for each service. This is a change from the previously used local codes that had one-hour time increments associated with them. Maximum allowable fees will be adjusted accordingly. As a result of this difference, providers will be required to use new rounding guidelines when submitting claims for case management services. Refer to Attachment 4 for the new rounding guidelines.

Type of service codes

Type of service codes will no longer be required on Medicaid claims.

Coverage for case management services

Medicaid coverage and documentation requirements for case management services remain unchanged. Refer to the Case Management Handbook and *Updates* for complete Medicaid policies and procedures.

Revision of CMS 1500 paper claim instructions

With the implementation of HIPAA, Medicaid-certified case management providers will be required to follow the revised instructions for the CMS 1500 paper claim form in this *Update,* even though the actual CMS 1500 claim form is not being revised at this time. Refer to Attachment 5 for the revised instructions. Attachment 6 is a sample of a claim for case management services that reflects the changes to the billing instructions.

Note: In some instances, paper claim instructions will be different from electronic claim instructions. Providers should refer to their software vendor's electronic billing instructions for completing electronic claims.

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Revisions made to the CMS 1500 claim form instructions

Revisions made to the instructions for the CMS 1500 paper claim include the following:

- Place of service codes were revised (Element 24B).
- Type of service codes are no longer required (Element 24C).
- Up to four modifiers per procedure code may be entered (Element 24D).

General HIPAA information

Refer to the following Web sites for more HIPAA-related information:

- *www.cms.gov/hipaa/* — Includes links to the latest HIPAA news and federal Centers for Medicare and Medicaid Services HIPAA-related links.
- *aspe.hhs.gov/admnsimp/* — Contains links to proposed and final rules, links to download standards and HIPAA implementation guides, and frequently asked questions regarding HIPAA and the Administrative Simplification provisions.

- *www.dhfs.state.wi.us/hipaa/* — Contains Wisconsin Department of Health and Family Services HIPAA-related publications, a list of HIPAA acronyms, links to related Web sites, and other valuable HIPAA information.

Information regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service information and applies to providers of services to recipients who have fee-for-service Medicaid. Since HIPAA impacts all health care payers, it is important to know that HIPAA changes, including changes from local procedure codes to national procedure codes, will also have an impact on Medicaid HMOs. For questions related to Medicaid HMOs or managed care HIPAA-related changes, contact the appropriate managed care organization.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *www.dhfs.state.wi.us/medicaid/*.

ATTACHMENT 1
Procedure code conversion chart for case management services

The following table lists the nationally recognized procedure code that providers will be required to use when submitting claims for case management services. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Before HIPAA implementation		**After HIPAA implementation**		
Local procedure code	**Local procedure code description**	**HCPCS* procedure code and description**	**First service modifier**	**Second service modifier (COP** or non-COP)**
W7051	Assessment	**T1017** Targeted case management, each 15 minutes	**U1** (assessment)	**U5** — COP **U6** — non-COP
W7061	Case planning	**T1017** Targeted case management, each 15 minutes	**U2** (case planning)	**U5** — COP **U6** — non-COP
W7071	Ongoing monitoring and service coordination	**T1017** Targeted case management, each 15 minutes	**U3** (ongoing monitoring and service coordination)	**U5** — COP **U6** — non-COP
W7062	Discharge planning	**T1017** Targeted case management, each 15 minutes	**U4** (discharge planning)	**U5** — COP **U6** — non-COP

*HCPCS — Healthcare Common Procedure Coding System.
**COP — Community Options Program.

ATTACHMENT 2
Place of service codes for case management services

The following table lists the nationally recognized place of service codes that providers will be required to use when submitting claims for case management services. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Place of service	Description
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room — Hospital
31	Skilled Nursing Facility
32	Nursing Facility
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
54	Intermediate Care Facility/Mentally Retarded
71	State or Local Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

ATTACHMENT 3
Target population conversion chart for case management services

The following table lists the *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis codes that will replace the locally assigned target population codes (Element 21) on the CMS 1500 claim form. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Before HIPAA implementation		**After HIPAA implementation**	
Local target population code	**Local target population code description**	**Replaced by ICD-9-CM* diagnosis code**	**ICD-9-CM diagnosis code description**
01A	Developmentally disabled	**315.9**	Unspecified delay in development
01B	Developmentally disabled, COP**		
03A	Birth to Three	**V79.3**	Developmental handicaps in early childhood
03B	Birth to Three, COP		
18A	Alcohol and other drug abuse	**304.9**	Unspecified drug dependence
18B	Alcohol and other drug abuse, COP		
31A	Chronically mentally ill	**V40.9**	Unspecified mental or behavioral problem
31B	Chronically mentally ill, COP		
36A	Alzheimer's Disease or Related Dementia	**294.8**	Other specified organic brain syndromes (chronic)
36B	Alzheimer's Disease or Related Dementia, COP		
44A	Tuberculosis	**V12.01**	Tuberculosis
44B	Tuberculosis, COP		
45A	Women age 45-64	**V15.9**	Unspecified personal history presenting hazards to health
45B	Women age 45-64, COP		
57A	Physically disabled	**V12.40**	Unspecified disorder of the nervous system and sense organs
57B	Physically disabled, COP		
58A	Age 65 and over	**V62.9**	Unspecified psychosocial circumstance
58B	Age 65 and over, COP		
64A	Under age 21 and severely emotionally disturbed	**313.9**	Unspecified emotional disturbance of childhood or adolescence
64B	Under age 21 and severely emotionally disturbed, COP		
72A	Asthma	**493.9**	Asthma, unspecified
72B	Asthma, COP		
88A	At-risk family	**V61.8**	Other unspecified family circumstances
88B	At-risk family, COP		
92A	HIV	**V08**	Asymptomatic human immunodeficiency virus (HIV) infection status
92B	HIV – COP		

* ICD-9-CM — *International Classification of Diseases, Ninth Edition, Clinical Modification*.
**COP — Community Options Program.

ATTACHMENT 4
Rounding guidelines for case management services

Time units are calculated based on rounding accumulated minutes of service for the month. The following chart illustrates the rules of rounding and gives the appropriate billing unit. A future *Wisconsin Medicaid and BadgerCare Update* will notify providers of the specific effective dates for Wisconsin Medicaid's implementation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Accumulated time	Unit(s) billed
1-5 minutes	.3
6-10 minutes	.7
11-15 minutes	1.0

A unit of service (1.0) is 11-15 minutes. Use the chart above to determine the appropriate unit(s).

ATTACHMENT 5
CMS 1500 claim form instructions for case management services
(for claims submitted after HIPAA implementation)

Use the following claim form completion instructions, ***not*** the element descriptions printed on the claim form, to avoid denied claims or inaccurate claim payment. Complete all required elements as appropriate. Do not include attachments unless instructed to do so.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Provider Resources section of the All-Provider Handbook or the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* for more information about the EVS.

Element 1 — Program Block/Claim Sort Indicator

Enter claim sort indicator "P" in the Medicaid check box for the service billed.

Element 1a — Insured's I.D. Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or the EVS to obtain the correct identification number.

Element 2 — Patient's Name

Enter the recipient's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 3 — Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/YYYY format (e.g., February 3, 1955, would be 02/03/1955). Specify whether the recipient is male or female by placing an "X" in the appropriate box.

Element 4 — Insured's Name (not required)

Element 5 — Patient's Address

Enter the complete address of the recipient's place of residence, if known.

Element 6 — Patient Relationship to Insured (not required)

Element 7 — Insured's Address (not required)

Element 8 — Patient Status (not required)

Element 9 — Other Insured's Name (not required)

Do not enter *anything* in this element.

Element 10 — Is Patient's Condition Related to (not required)

Element 11 — Insured's Policy, Group, or FECA Number (not required)

Do not enter *anything* in this element.

Elements 12 and 13 — Authorized Person's Signature (not required)

Element 14 — Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 — If Patient Has Had Same or Similar Illness (not required)

Element 16 — Dates Patient Unable to Work in Current Occupation (not required)

Elements 17 and 17a — Name and I.D. Number of Referring Physician or Other Source (not required)

Element 18 — Hospitalization Dates Related to Current Services (not required)

Element 19 — Reserved for Local Use (not required)

Element 20 — Outside Lab? (not required)

Element 21 — Diagnosis or Nature of Illness or Injury

Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code assigned to the target population.

Element 22 — Medicaid Resubmission (not required)

Element 23 — Prior Authorization Number (not required)

Element 24A — Date(s) of Service

Enter the month, day, and year for each service using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY or MM/DD/YYYY format in the "From" field.
- For all case management services, if the service was performed on more than one date of service within the month, indicate the last date of service on the claim form.

Although a given month's ongoing monitoring may only be billed once, more than one month's ongoing monitoring may be billed on a single claim form. In that case, use one detail line for each month's ongoing monitoring with the date of service determined as described above.

Element 24B — Place of Service

Enter the appropriate two-digit place of service code for each service.

Element 24C — Type of Service (not required)

Element 24D — Procedures, Services, or Supplies

Enter the single most appropriate five-character procedure code. Wisconsin Medicaid denies claims received without an appropriate procedure code.

Modifiers

Enter the appropriate modifier(s) in the "Modifier" column of Element 24D.

Element 24E — Diagnosis Code

Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code listed in Element 21.

Element 24F — $ Charges

Enter the total charge for each line item.

Element 24G — Days or Units

Enter the appropriate number of time increments for each procedure. Always use a decimal (e.g., 2.0 units) and round according to guidelines for case management services.

Element 24H — EPSDT/Family Planning (not required)

Element 24I — EMG (not required)

Element 24J — COB (not required)

Element 24K — Reserved for Local Use (not required)

Element 25 — Federal Tax I.D. Number (not required)

Element 26 — Patient's Account No. (not required)

Optional — Providers may enter up to 20 characters of the patient's internal office account number. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice transaction.

Element 27 — Accept Assignment (not required)

Element 28 — Total Charge

Enter the total charges for this claim.

Element 29 — Amount Paid (not required)

Element 30 — Balance Due

Enter the balance due. This will be the same amount as appears in Element 28.

Element 31 — Signature of Physician or Supplier

The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/YYYY format.

Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 32 — Name and Address of Facility Where Services Were Rendered (not required)

Element 33 — Physician's, Supplier's Billing Name, Address, ZIP Code, and Phone

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.

ATTACHMENT 6
Sample CMS 1500 claim form
for case management services

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) | MEDICAID ☐ (Medicaid #) | CHAMPUS ☐ (Sponsor's SSN) | CHAMPVA ☐ (VA File #) | GROUP HEALTH PLAN ☐ (SSN or ID) | FECA BLK LUNG ☐ (SSN) | OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY | SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow St

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown | STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY | STATE

ZIP CODE: 55555 | TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX: M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. V15.9
2.
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10 21 03		71		T1017	U1 U5	1	XX XX	5.0				
2 10 29 03		12		T1017	U2 U5	1	XX XX	5.3				
3 11 25 03		12		T1017	U3 U5	1	XX XX	8.7				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $ XX XX

29. AMOUNT PAID $

30. BALANCE DUE $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

J.M. Authorized MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M. Billing
1 W. Williams
Anytown, WI 55555 87654321

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION